STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

April 13, 1990

ALL-COUNTY LETTER NO. 90-36

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY GAIN COORDINATORS

SUBJECT: REVISION OF WORKERS' COMPENSATION INSURANCE PROCEDURES FOR PARTICIPANTS IN A GAIN PREEMPLOYMENT PREPARATION (PREP) ASSIGNMENT

The purpose of this letter is to advise the Counties of changes in the workers' compensation law that affect PREP participants in the Greater Avenues for Independence (GAIN) Program.

The Legislature recently passed AB 276 and SB 47 effective January 1, 1990. These two bills are known as the Workers' Compensation Reform Act (WCRA) of 1989. The WCRA's primary purpose is to adjust the amount of compensation benefits and to ensure that all workers are aware of their right to compensation benefits from work related injuries or illnesses.

One of the most significant changes in the WCRA is the institution of the Employee Claim Form (SCIF 3301). Within 24 hours of becoming aware of an injury, the GAIN PREP site supervisor must provide the GAIN PREP participant with a claim form on which the participant will describe the circumstances of the injury. The completed form is to be filed with the supervisor, who must then date it, give a copy to the participant and send the original to the local State Compensation Insurance Fund (SCIF) office and keep a copy for office reports.

The claim form does not replace the Employer's Report of Injury (SCIF 3067). The supervisor must still file this report. The SCIF 3301 and the SCIF 3067 must be completed and mailed to the nearest SCIF office as soon as possible with a copy sent to the County Welfare Department.

A second major change is the imposition of a 10 percent penalty for late payment of benefits. The SCIF is allowed 14 days from the date the claim form is submitted to the PREP site supervisor to make the first disability payment or deny the claim. After

the 14 days, a 10 percent penalty (up to $5,000) is assessed for late payments. Under the provisions of the WCRA, until the PREP participant files the claim form, he/she will not have the right to pursue litigation nor collect penalties for late payment of benefits.

We have enclosed a copy of the new Employee Claim form (SCIF 3301), Employer's Report of Injury (SCIF 3067) and a copy of the notice that should be posted at each PREP site location in a conspicuous place advising the PREP participant of his/her rights to workers' compensation benefits. Also included for your information is "Steps To Follow When an Injury Occurs" and a listing of SCIF District Office Mailing Addresses. Please contact your local SCIF district office to request necessary forms.

Please review these documents carefully. If you have any questions related to completing the forms, please contact Mr. Ralph L. Maurer, Chief of Office of Insurance and Risk Management (OIRM) in the Department of General Services at (916) 322-8971 or Ms. Marianne Kemp (OIRM) at (916) 323-3866.

If you have any other questions regarding the information in this letter, please contact your County GAIN Operations Analyst at (916) 324-6962.

DENNIS J. BOYLE
Deputy Director

Enclosures

cc: CWDA

S. S TO FOLLOW WHEN AN INJURY CCURS

All GAIN/PREP participants are covered for workers' compensation benefits through the State Department of Social Services under a contract with the State Compensation Insurance Fund (SCIF). The contract number is CONTRG #0. All benefits are administered and authorized through the State Compensation Insurance Fund. Your local State Fund phone numbers are enclosed.

The participant's employer is "GAIN/PREP", a State sponsored work program. The program is permissibly uninsured. For purposes of completing claim forms, enter the SCIF contract number, CONTRG #0, whenever a "policy number" is requested.

If a GAIN/PREP participant is injured, the PREP agency should take the following steps:

1. Provide first aid (if trained staff is available).

2. Take the injured participant for appropriate medical care, if necessary. If there is a serious injury, call an ambulance if appropriate. If the injury is not serious, a local clinic or physician's office can usually provide service at a lower cost than a hospital emergency room. If a trainee has previously designated a treating physician in writing, he/she may elect to receive care from his/her own doctor. If not, the worksite supervisor may direct and assist him/her to the nearest medical facility.

3. Provide an Employee Claim Form (SCIF 3301, 1/90) for workers' compensation benefits to the injured participant within one working day of injury. If possible, have the worker complete and return the form to you immediately. Send the original of the Employee Claim Form to your local SCIF office, provide a copy to the injured worker and keep a dated copy for your records.

4. Investigate the circumstances of the injury and prepare an Employer's Report of Occupational Injury or Illness (SCIF 3067, 8/88). Send the Employer's Report to your local SCIF office. Do not wait for the doctor's first report or the Employee Claim Form before sending your Employer's Report to SCIF.

5. The medical provider should be advised that GAIN/PREP participants are covered for workers' compensation. All benefits are administered and authorized by the State Compensation Insurance Fund. Any requests for medical authorization should be directed to the local SCIF office.

If you have any questions regarding workers' compensation coverage, you may contact the local SCIF office and ask for the GAIN claims adjuster, or call the GAIN workers' compensation coordinator in the State Office of Insurance and Risk Management at (916) 323-3866.

PLEASE TYPE ALL INFORMATION, IF POSSIBLE

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate. Retain last copy for your files and mail the original and one copy to **STATE COMPENSATION INSURANCE FUND** **CONTRACT ADMINISTRATION** P.O. BOX 12971, OAKLAND, CA 94604-2971 Telephone: (415) 577-3000	OSHA Case or File No.

TYPEWRITER ALIGNMENT GUIDE — PICA XXX ELITE XXX

California law requires an employer to report within five days every industrial injury or occupational disease which (a) results in lost time beyond the day of injury or (b) requires medical treatment other than first aid. PLEASE NOTE: In addition, if death results or if the injury or illness: (a) requires inpatient hospitalization of more than 24 hours for other than medical observation, or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified **immediately** by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYER

1. FIRM NAME / DIVISION: GAIN/PREP Department of Public Works Shasta County
1A. CONTRACT NUMBER: CONTRG#0
2. MAILING ADDRESS (Number and Street, City, ZIP): ABC Street Redding, CA 96001
2A. PHONE NUMBER: (916)555-4000
3. LOCATION, IF DIFFERENT FROM MAIL ADDRESS (Number and Street, City, ZIP):
3A. LOCATION CODE: 450 (see att.)
4A. NATURE OF BUSINESS e.g. painting contractor, wholesale grocer, sawmill, hotel, etc.: Public Works
5. STATE UNEMPLOYMENT INSURANCE ACCT NO: N/A
4B. TYPE OF EMPLOYER: PRIVATE / STATE / CITY / COUNTY / SCHOOL DISTRICT / OTHER GOVERNMENT X / SPECIFY: State sponsored work program

EMPLOYEE

6. EMPLOYEE NAME: Jane Doe
7. DATE OF BIRTH (MM-DD-YY): 01-29-69
8. HOME ADDRESS (Number and Street, City, ZIP): 32 Harbor Blvd. Redding, CA 96001
8A. PHONE NUMBER: (916)555-8888
9. SEX: Male / Female X
10. OCCUPATION (Regular job title, not specific activity at time of injury): Clerk Typist
11. SOCIAL SECURITY NUMBER: 323-44-8890
12. DEPARTMENT IN WHICH REGULARLY EMPLOYED: Office Support
12A. DATE OF HIRE (MM-DD-YY): 12-10-89
13. HOURS USUALLY WORKED: HOURS PER DAY 8 — 13A. DAYS PER WEEK 5 — 13B. TOTAL WEEKLY HOURS 40
13C. Under what class code of your policy were wages assigned? N/A
14. GROSS WAGES/SALARY: Cash Grant 768.00 * PER: HOUR / DAY / WEEK / TWO WEEKS / MONTH X / OTHER - SPECIFY: *contact County Social Services

INJURY OR ILLNESS

15. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and Street, City): on the premises ABC St. Redding
15A. COUNTY: Shasta
15B. ON EMPLOYER'S PREMISES? YES X NO
16. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.): Fell off a chair while typing
17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.): Fell off a chair while typing; injured lower back.
18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g. the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the thing he was lifting, pulling, etc.: Fell onto floor.
19A. DESCRIBE THE INJURY OR ILLNESS e.g. cut, strain, fracture, skin rash, etc.: Back Strain
19B. PART OF BODY AFFECTED e.g. back, left wrist, right eye, etc.: lower back
20. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP): Dr. Feelgood, 111 P St., Redding, CA 98001
21. IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP): N/A
22. DATE OF INJURY OR ILLNESS (MM-DD-YY): 01-13-90
23. TIME OF DAY: 03:30 a.m. / p.m. X
24. Did employee lose at least one full day's work after the injury? NO / X YES - Date Last Worked (MM-DD-YY): 01-13-90
25. HAS EMPLOYEE RETURNED TO WORK? No, still off work / X Yes, date returned (MM-DD-YY): 01-20-90
26. DID EMPLOYEE DIE? X NO / YES — Date of Death (MM-DD-YY)
27. WAS ANOTHER PERSON RESPONSIBLE? X NO / YES
28. WAS INJURED AN EXECUTIVE OFFICER OR A PARTNER? X NO / YES

Completed by (type or print)	Signature	Title	Date

PLEASE DO NOT USE THIS COLUMN: CASE NO. / OWNERSHIP / INDUSTRY / OCCUPATION / SEX / AGE / DAILY HOURS / DAYS PER WEEK / WEEKLY HOURS / WEEKLY WAGE / COUNTY / NATURE OF INJURY / PART OF BODY / SOURCE / ACCIDENT TYPE / A.O.S. / EXTENT OF INJURY / CODED BY

SCIF 3067 CONTRACT (REV. 8-88)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. NOTICE OF WORKERS' COMPENSATION BENEFITS MUST BE GIVEN TO INJURED WORKER WITHIN 5 DAYS OF YOUR KNOWLEDGE OF THIS INJURY

FORM 5020 (REV 5) April 1987

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

SAMPLE ONLY

EXHIBIT A

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

NAME	DATE OF INJURY OR ILLNESS	TIME OF DAY
	/ /	☐ A.M. ☐ P.M.

HOME ADDRESS (Number, Street, City , Zip Code)

WHERE DID ACCIDENT OR EXPOSURE OCCUR (Number, Street, City, Zip Code)

DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED

NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

You may be entitled to one or more of the following benefits provided for you at your employer's expense, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of your employer's notice or knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

YOU MUST FILE THIS CLAIM FORM WITH YOUR EMPLOYER TO PROTECT YOUR RIGHTS

Failure to file this claim form will preclude you from receiving any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1/ (415) 557-1954. This service is provided to you at no cost . You also may consult an attorney.

I gave this form to my employer on (date) _____, 19_____.

EMPLOYEE: Keep copy marked "EMPLOYEE'S TEMPORARY RECEIPT " until you receive the dated copy from your employer.

EMPLOYER FILLS OUT THIS PART

Date of knowledge of injury	Date claim form was provided to employee	Date claim form was received
01 / 13 / 90	01 / 13 / 90	01 / 13 / 90

Name of Employer
GAIN/PREP Department of Public Works

Signature of Employer/Representative
Worksite Supervisor

Employer: You are required to date this form and provide copies as marked, to your insurer and to the employee, dependent or agent who filed the claim.
Signing this form does not necessarily constitute acceptance of a claim.
Please return original to your local State Fund office.

STATE COMPENSATION INSURANCE FUND

SCIF 3301 (NEW 1-90)

STATE FUND COPY

LIST OF COUNTY LOCATION CODE AND STATE FUND OFFICES

(For mailing addresses, see reverse side of SCIF 3067 claim form).

COUNTY	LOCATION CODE	STATE FUND OFFICE	TELEPHONE
ALAMEDA	010	OAKLAND	(415) 638-1500
ALPINE	020	STOCKTON	(209) 951-8000
AMADOR	030	STOCKTON	(209) 951-8000
BUTTE	040	REDDING	(916) 223-7000
CALAVERAS	050	STOCKTON	(916) 951-8000
COLUSA	060	SACRAMENTO	(916) 924-5100
CONTRA COSTA	070	OAKLAND	(415) 638-1500
DEL NORTE	080	EUREKA	(707) 443-9721
EL DORADO	090	SACRAMENTO	(916) 924-5100
FRESNO	100	FRESNO	(209) 445-5858
GLENN	110	REDDING	(916) 223-7000
HUMBOLDT	120	EUREKA	(707) 443-9721
IMPERIAL	130	SAN DIEGO	(619) 552-7100
INYO	140	SAN BERNARDINO	(714) 884-7281
KERN	150	BAKERSFIELD	(805) 834-8300
KINGS	160	FRESNO	(209) 445-5858
LAKE	170	SANTA ROSA	(707) 576-2565
LASSEN	180	REDDING	(916) 223-7000
LOS ANGELES	190	STATE CONTRACT	(213) 266-5500
MADERA	200	FRESNO	(209) 445-5858
MARIN	210	SANTA ROSA	(707) 576-2565
MARIPOSA	220	STOCKTON	(209) 951-8000
MENDOCINO	230	SANTA ROSA	(707) 576-2565
MERCED	240	STOCKTON	(209) 951-8000
MODOC	250	REDDING	(916) 223-7000
MONO	260	STOCKTON	(209) 951-8000
MONTEREY	270	SAN JOSE	(408) 297-1714
NAPA	280	SANTA ROSA	(707) 576-2565
NEVADA	290	SACRAMENTO	(916) 924-5100
ORANGE	300	STATE CONTRACT	(213) 266-5500
PLACER	310	SACRAMENTO	(916) 924-5100
PLUMAS	320	REDDING	(916) 223-7000
RIVERSIDE	330	SAN BERNARDINO	(714) 884-7281
SACRAMENTO	340	SACRAMENTO	(916) 924-5100
SAN BENITO	350	SAN JOSE	(408) 297-1714
SAN BERNARDINO	360	SAN BERNARDINO	(714) 884-7281
SAN DIEGO	370	SAN DIEGO	(619) 552-7100
SAN FRANCISCO	380	SAN FRANCISCO	(415) 565-1234
SAN JOAQUIN	390	STOCKTON	(209) 951-8000
SAN LUIS OBISPO	400	VENTURA	(805) 644-4300
SAN MATEO	410	SAN FRANCISCO	(415) 565-1234
SANTA BARBARA	420	VENTURA	(805) 644-4300
SANTA CLARA	430	SAN JOSE	(408) 297-1714
SANTA CRUZ	440	SAN JOSE	(408) 297-1714
SHASTA	450	REDDING	(916) 223-7000
SIERRA	460	SACRAMENTO	(916) 924-5100
SISKIYOU	470	REDDING	(916) 223-7000
SOLANO	480	SACRAMENTO	(916) 924-5100
SONOMA	490	SANTA ROSA	(707) 576-2565
STANISLAUS	500	STOCKTON	(209) 951-8000
SUTTER	510	SACRAMENTO	(916) 924-5100
TEHAMA	520	REDDING	(916) 223-7000
TRINITY	530	REDDING	(916) 223-7000
TULARE	540	FRESNO	(209) 445-5858
TUOLUMNE	550	STOCKTON	(209) 951-8000
VENTURA	560	VENTURA	(805) 644-4300
YOLO	570	SACRAMENTO	(916) 924-5100
YUBA	580	SACRAMENTO	(916) 924-5100

District Office Mailing Addresses

ARCADIA
P.O. Box 915
Arcadia, CA 91066-0915
(818) 574-2600

BAKERSFIELD
P.O. Box 9729
Bakersfield, CA 93389-9729
(805) 664-4000

CERRITOS
P.O. Box 6165
Cerritos, CA 90702-6165
(213) 809-6600

EUREKA
P.O. Box 4973
Eureka, CA 95502-4973
(707) 443-9721

FRESNO
P.O. Box 40000
Fresno, CA 93755-4000
(209) 445-5858

LOS ANGELES
P.O. Box 2134, Terminal Annex
Los Angeles, CA 90051-0134
(213) 266-5000

OAKLAND
P.O. Box 12971
Oakland, CA 94604-2971
(415) 577-3000

REDDING
P.O. Box 496049
Redding, CA 96049-6049
(916) 223-7000

RIVERSIDE
P.O. Box 5025
Riverside, CA 92517-5025
(714) 656-8300

SACRAMENTO
P.O. Box 254700
Sacramento, CA 95865-4700
(916) 924-5100

SAN BERNARDINO
P.O. Box 1316
San Bernardino, CA 92402-1316
(714) 384-4500

SAN DIEGO
P.O. Box 85488
San Diego, CA 92138-5488
(619) 552-7000

SAN FRANCISCO
P.O. Box 807
San Francisco, CA 94101-0807
(415) 565-1344

SAN JOSE
P.O. Box 759
San Jose, CA 95106-0759
(408) 297-1714

SANTA ANA
P.O. Box 419
Santa Ana, CA 92702-0419
(714) 567-2800

SANTA ROSA
P.O. Box 2407
Santa Rosa, CA 95405-0407
(707) 576-2565

SOUTH ORANGE COUNTY
P.O. Box 1685
Costa Mesa, CA 92628-1685
(714) 668-3445

STOCKTON
P.O. Box 8000
Stockton, CA 95208-0016
(209) 476-2600

VENTURA
P.O. Box S
Ventura, CA 93002-2268
(805) 644-4300

WEST LOS ANGELES
P.O. Box 2518
Culver City, CA 90231-2518
(213) 965-2100

WOODLAND HILLS
P.O. Box 1950
Woodland Hills, CA 91365-1950
(818) 888-4750

STATE COMPENSATION INSURANCE FUND

CONTAINED ON THIS NOTICE IN A CONSPICUOUS LOCATION
FREQUENTED BY EMPLOYEES AND WHERE SUCH NOTICE MAY BE
EASILY READ BY EMPLOYEES DURING THE COURSE
OF THE WORK DAY.

NOTICE TO EMPLOYEES

Our Workers' Compensation Insurer is: STATE COMPENSATION INSURANCE FUND

If a job injury occurs...

If you become injured or ill because of your job, you will be entitled to automatic benefits under the California Workers' Compensation Law. These benefits include:

Medical Care—All authorized medical expenses are fully covered. If you need medical care, you will be referred to a local doctor. To change doctors, ask your supervisor. Should you still need care 30 days after reporting the injury, you may be treated by a physician of your own choice. (You may be treated by your own personal physician immediately following your injury if you have notified your employer in writing before the injury occurs of the name and address of your personal physician.) For further information, please contact your supervisor.

Disability Income—If hospitalized, or unable to work for more than three days, you will receive income equal to two-thirds of your average weekly pay, up to a legal maximum per week. If you receive a permanent handicap, additional payments will be provided.

Rehabilitation—If your injury or illness prevents you from returning to your same job, you may be eligible for vocational rehabilitation and retraining.

Death Benefits—Should the injury cause death, a benefit will be paid to dependents.

***Important**—Always immediately notify your supervisor of any work-related injury or illness. If you have any questions or would like more details about workers' compensation benefits, please see your supervisor.*

When a job injury occurs...

Be sure that:

Emergency Phone Numbers: